

CERTIFICATE OF DEATH

Reg. Dist. No. 62

8515

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Cecil</u> MARYLAND		STATE <u>Penn</u> COUNTY		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Patterson</u> 75X-3		STREET ADDRESS (If rural give location)	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Deerfield</u> 4 miles		LENGTH OF STAY (in this place)		HOSPITAL OR INSTITUTION OR STREET ADDRESS			
3. NAME OF DECEASED: (Type or Print) <u>Lizzie</u> (First) <u>Bluma</u> (Middle) <u>Lauplan</u> (Last)				4. DATE OF DEATH: (Month) <u>Sept</u> (Day) <u>18</u> (Year) <u>1955</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH: <u>Sept. 4, 1873</u>	9. AGE last birthday: <u>82</u> yrs.	IF UNDER 1 YEAR: Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>house</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Patterson</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME: <u>David Tetter</u>				14. MOTHER'S MAIDEN NAME: <u>Sara Zenger</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>9</u>		16. SOCIAL SECURITY No.: <u>1</u>		17. INFORMANT'S ADDRESS: <u>Park Lauplan, Deerfield</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.2 Immediate cause (a) <u>Pulmonary edema</u> DUE TO							
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Myocarditis Chronic</u> DUE TO							
(c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>0</u>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, or office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 9, 1955</u> , to <u>Sept 18, 1955</u> , that I last saw the deceased alive on <u>9-17, 1955</u> , and that death occurred at <u>7 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Lawson D George MD</u> (Degree or title)				DATE SIGNED <u>9/20/55</u>			
23. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Sept 21st</u>		NAME OF CEMETERY OR CREMATORY <u>Highland Memorial</u>		LOCATION (City, town, or county) <u>Patterson, Pa</u>	
DATE REC'D BY LOCAL REGISTRAR <u>9/20/55</u>		REGISTRAR'S SIGNATURE <u>Wm D George</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Virgil Moore</u>		ADDRESS <u>Deerfield</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

SEP 23 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08524

8516

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Caroline</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Caroline</u>			
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>Preston - Rural</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Preston - Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Near Harmony</u>				STREET ADDRESS (If rural give location) <u>Near Harmony</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Robert Wilmore James</u>				<u>September 30 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>Colored</u>	<u>Widowed</u>	<u>May 14, 1891</u>	<u>64</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Day Laborer</u>		<u>Farm</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Unknown</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>Yes</u> <u>WW I</u>				<u>220-26-8241</u>		<u>Rev. N.C. Stanley, Denton, Md., R.F.D.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE						<u>1 yr +</u>	
(A) <u>Chronic Myocardial Degeneration</u>							
ANTECEDENT CAUSE (S):						<u>1 yr +</u>	
(B) <u>General Atherosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 1, 1955</u> , to <u>Oct 5, 1955</u> , that I last saw the deceased alive on <u>Oct 1, 1955</u> , and that death occurred at <u>9:10 M.</u> from the causes and on the date stated above.							
SIGNATURE		M. D.		DATE SIGNED			
<u>W. C. Harrison</u>		<u>Harlock Md</u>		<u>10/3/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Oct. 4, 1955</u>		<u>Harmony Cemetery</u>		<u>Near Preston, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>10-4-55</u>		<u>Conrad W. Plummer</u>		<u>J.J. Frampton and Son, Federalsburg, Md.</u>			

BUREAU V. S.

OCT 7 1965

RECEIVED

8517

CERTIFICATE OF DEATH

Reg. Dist. No. *60*

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Caroline</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Caroline</i>	
CITY (If outside corporate limits, write RURAL OR TOWN) <i>X</i> <i>Templerville</i>		LENGTH OF STAY (in this place) <i>64 yrs</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Templerville</i> <i>X</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>None</i>				STREET ADDRESS (If rural give location) <i>None</i>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<i>EARL MOORE</i>				<i>Sept 20 1900</i>			
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Single</i>	8. DATE OF BIRTH: <i>2/2/1891</i>	9. AGE last birthday <i>64</i> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, or on it retired): <i>Retired Carpenter</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>None</i>		11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>Isaac Moore</i>				14. MOTHER'S MAIDEN NAME: <i>Sarah Everett</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service) <i>213-18-5297</i>		17. INFORMANT & ADDRESS: <i>Laura Mc Knatt Templerville Md.</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Cardio Vascular Disease</i>						<i>10 yrs</i>	
ANTECEDENT CAUSE (B) <i>Hypertension</i>						<i>10 yrs</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>None</i>							
19A. DATE OF OPERATION: <i>0</i>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>None</i>			
22. I hereby certify that I attended the deceased from <i>Jan 1, 1949</i> to <i>Sept 20, 1955</i> ; that I last saw the deceased alive on <i>9/1/55</i> , 19 <i>55</i> , and that death occurred at <i>10:15</i> AM, from the causes and on the date stated above.							
SIGNATURE <i>J. H. Hamilton</i>				ADDRESS <i>Millington Md</i>		DATE SIGNED <i>9/21/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>9/23/55</i>		NAME OF CEMETERY OR CREMATORY <i>Templerville</i>		LOCATION (City, town, or county) (State) <i>Templerville Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>9/23/55</i>		REGISTRAR'S SIGNATURE <i>J. E. Boulaie</i>		FURNEL DIRECTOR <i>J. E. Boulaie</i>		ADDRESS <i>Greensboro, Md.</i>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

DEC 4 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

08526

Reg. Dist. No. 61

8518

1. PLACE OF DEATH COUNTY <u>Caroline</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> TOWN <u>Rural Greensboro</u> LENGTH OF STAY (in this place) <u>5 Yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Greensboro</u> <input checked="" type="checkbox"/>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None</u>		STREET ADDRESS (If rural, give location) <u>None</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Harry</u> (Middle) <u>Rody</u> (Last) <u>Morris</u>		4. DATE OF DEATH (Month) <u>9</u> (Day) <u>30</u> (Year) <u>55</u> 19	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Single</u>	8. DATE OF BIRTH <u>10/18/1889</u>
9. AGE last birthday <u>65</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Tenant</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William E. Morris</u>		14. MOTHER'S MAIDEN NAME <u>Anna Turner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mary Dorman Greensboro, Md.</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH. Immediate cause (a) <u>431X Typhoiditis Acute</u> Antecedent cause(s) (b) <u>Exhaustion</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>10/3/55</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>Dan G. Taylor</u>		DATE SIGNED <u>10/3/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>10/3/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Greensboro</u>		LOCATION (City, town, or county) (State) <u>Greensboro, Md.</u>	
DATE REC'D BY LOCAL REG. <u>10/3/55</u>		24. FUNERAL DIRECTOR <u>J. E. Boules</u> ADDRESS <u>Greensboro, Md.</u>	

RECEIVED

OCT 5 1935

BUREAU V. S.

8519

CERTIFICATE OF DEATH

Reg. Dist. No. 6/

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Caroline</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Greensboro</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Greensboro</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 Tribbitt Nursing Home</u>		STREET ADDRESS (If rural give location) <u>None</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) (Middle) (Last)		OF DEATH: <u>9</u> <u>14</u> <u>55</u> <u>19</u>	
(Type or Print) <u>Luman</u> <u>M.</u> <u>Strong</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE. MARRIED. WIDOWED. DIVORCED.	8. DATE OF BIRTH:
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>?/?/1873</u>
9. AGE last birthday: <u>82</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Wisconsin</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired Telegraph Operator</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>No Record</u>		14. MOTHER'S MAIDEN NAME: <u>No Record</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>S.P.A. & War 1</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Mildred M. Ginn Greensboro, Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
334X IMMEDIATE CAUSE ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			<u>Cerebral & General Arteriosclerosis</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Sept. 5</u> , 19 <u>55</u> to <u>Sept. 14</u> , 19 <u>55</u> that I last saw the deceased alive on <u>Sept. 13</u> , 19 <u>55</u> , and that death occurred at <u>1:10 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Charles H. Hunsicker</u> M.D.		ADDRESS <u>Greensboro, Md.</u> DATE SIGNED <u>Sept 14/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9/18/55</u> NAME OF CEMETERY OR CREMATORY <u>Dodgeville</u> LOCATION (City, town, or county) (State) <u>Dodgeville, Wisconsin</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Sept. 15 - 1955</u>		REGISTRAR'S SIGNATURE <u>L. Man Pappin</u> 24. CORONER DIRECTOR <u>J. E. Boulois</u> ADDRESS <u>Greensboro, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 19 1955

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

09601

8520

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 64

1. PLACE OF DEATH- COUNTY <u>Caroline</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Federalburg</u> TOWN <u>Federalburg</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		MARYLAND LENGTH OF STAY (in this place)		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Caroline</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Federalburg</u> TOWN <u>Federalburg</u> STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) <u>Guy</u> (Middle) <u>K.</u> (Last) <u>Wheatley</u>		4. DATE OF DEATH (Month) <u>Sept.</u> (Day) <u>28</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 19, 1891</u>	9. AGE last birthday <u>64</u> yrs.	10. If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Poultry Farms</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
13. FATHER'S NAME <u>Henry M. Wheatley</u>		14. MOTHER'S MAIDEN NAME <u>Vivie Eskridge</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>World War I</u>		16. SOCIAL SECURITY NO. <u>217-05-9206</u>		17. INFORMANT AND ADDRESS <u>Raymond Wheatley - Federalburg R 20</u>	
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH	
830X Immediate cause (a) <u>Internal Pyrosis</u>				<u>Immediate</u>	
Antecedent cause(s) (b) <u>Crushed by Truck</u>				<u>1</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office, bldg, etc.) <u>Caroline Poultry Farms</u>		(CITY OR TOWN) <u>Federalburg</u> (COUNTY) <u>Caroline</u> (STATE) <u>Md.</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Sept 28 1955 3:45 PM</u>		INJURY OCCURRED While at Work <input checked="" type="checkbox"/> Not While Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR? <u>05</u>	
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....m., from the causes and on the date stated above.					
SIGNATURE <u>Dawson O. George</u>		(Degree or title) <u>Deputy Medical Examiner</u>		ADDRESS <u>Federalburg R. 20 Md.</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Oct. 2, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Cokebury Cemetery</u>	
LOCATION (City, town, or county) <u>Federalburg R. 20 Md.</u>		24. FUNERAL DIRECTOR <u>J. Harvey Williamson</u>		ADDRESS <u>Federalburg Md.</u>	
DATE REC'D BY LOCAL REG. <u>Oct. 1, 1955</u>		REGISTRAR'S SIGNATURE <u>Everett Nettle</u>		ADDRESS <u>Deputy</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 10 1955

RECEIVED